Underwritten by

PacifiCare®

Life and Health Insurance Company

PacifiCare®

Retiree Plans℠

PacifiCare Senior Supplement Indemnity Plan Summary

Plan C (III)

All covered amounts will vary depending on Medicare benefits for any particular year. Amounts listed on this summary are for Year 2009 benefits. Amounts may change for the Year 2010. This summary is intended only to show highlights of benefits and should not be relied upon to fully determine health care expenses. Please refer to the group health insurance certificate for a listing of services, limitations, exclusions, and a description of the terms, conditions of coverage and any state mandated benefits. If this description conflicts in any way with the policy issued to the enrolling group, the policy prevails.

A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

LIFETIME POLICY MAXIMUM **$2,000,000 per Covered Person**

Covered Service	Medicare Pays	Senior Supplement Pays	You Pay
Hospitalization			
Semi-private room and board, general nursing and miscellaneous services and supplies.			
Part A hospital — first 60 days	All but $1,068	$1,068 (Part A Deductible)	$0
Part A hospital — days 61 – 90	All but $267 per day	$267 per day	$0
Part A hospital — day 91 and after:			
While using 60 lifetime reserve days	All but $534 per day	$534 per day	$0
After 60 lifetime reserve days are used:			
▪ 365 lifetime additional days	$0	100% of Medicare Eligible Expenses	$0
▪ Beyond 365 lifetime additional days	$0	$0	All costs
Blood			
First 3 pints Medicare Part A or B	$0	100%	$0
Additional amounts under Part A Medicare	100%	$0	$0
Next $135 of Medicare Approved Amounts under Part B Medicare	$0	$135 (Part B Deductible)*	$0
Remainder of Medicare Approved Amounts under Part B Medicare	80%	20%	$0
Skilled Nursing Facility Care			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entering the Medicare approved facility within 30 days of leaving the hospital.			
Days 1 – 20	All approved amounts	$0	$0
Days 21 – 100	All but $133.50 per day	Up to $133.50 per day	$0
Days 101 and after	$0	$0	All costs

** Once you have been billed $135 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.*

Covered Service	Medicare Pays	Senior Supplement Pays	You Pay
Hospice Care			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	Balance	$0
Home Health Care			
Skilled Care Services and Medical Supplies	All approved amounts	$0	$0
Durable Medical Equipment			
First $135 of Medicare Approved Amounts	$0	$135 (Part B Deductible)*	$0
Remainder of Medicare Approved Amounts	80% of approved amounts	20% of approved amounts	$0
Medical Services			
Includes services such as Physician services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy and diagnostic tests.			
First $135 of Medicare Approved Amounts	$0	$135 (Part B Deductible)*	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Outpatient Mental Illness			
■ For most outpatient mental illness services	50%	50%	$0
Part B Excess Charges (above Medicare Approved Amounts)	$0	$0	All costs
Foreign Travel			
Medically Necessary Emergency Care services beginning during the first 60 days of each trip outside the United States.			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% up to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

* *Once you have been billed $135 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.*

Exclusions and Limitations

No benefits will be provided for, or in connection with, the following treatments, services or supplies:

- Any expense or service that is not determined by the Company to be a Medicare Eligible Expense, unless coverage for the expense or service is specifically provided by a Rider to the Policy. Any treatment, service or supply paid for by Medicare or found to be medically unnecessary or unnecessary by Medicare. Any treatment, service or supply that is provided before the effective date of coverage or after coverage has terminated.
- Any injury or sickness due to any past or present employment, or that is covered under any Workers' Compensation law or similar law. Charges for self-inflicted injury or attempted suicide. Any treatment, confinement, services or supply provided by a government owned or operated facility. Any injury or sickness resulting from war or any act of war (declared or undeclared). Acts beyond the company's control such as any major disaster, epidemic, complete or partial destruction of facility, war, riot, or civil insurrection, which result in the unavailability of the facilities or personnel. Charges incurred as a result of participation in a riot, insurrection or the commission of a felony.
- Blood and plasma except as stated above. Experimental or investigational treatment, procedures and items. Hospital expenses for days 366 and beyond after the Medicare 60 lifetime reserve days have been used. Preventive Care (except to the extent charges are approved for coverage under Medicare). Medicare Part B Excess Charges. At-Home Recovery Visits for services provided for short term, at-home assistance with the Activities of Daily Living for a Covered Person who is recovering from a sickness, injury or surgery. Prescription Drugs unless provided by Rider. Mental illness, alcoholism and drug addiction (except to the extent charges are approved for coverage under Medicare).

This Plan Summary is a highlight of benefits only and is not all inclusive of the Plan's benefits, services, or Exclusions and Limitations. Please refer to the Schedule of Benefits and the Certificate of Coverage for additional details.

For additional information, contact your employer or call:

1-800-698-0822

or for the hearing impaired:

TTY: 711

Retiree Benefits Summary Insert

Prepared Exclusively For: IBEW #413
Group Number 145666 (H0543 805)
Effective January 1, 2009 to December 31, 2009

Insured by: PacifiCare of California

This is a highlight of benefits only and is not all inclusive of the Plan's benefits, services, limitations or exclusions. Please refer to the enclosed Retiree Benefits Summary booklet and your Evidence of Coverage and Disclosure Information for additional details. Keep this Retiree Benefits Summary Insert, together with your Retiree Benefits Summary, handy for your reference.

For general questions prior to enrollment call 1-800-610-2660, or for the hearing impaired TTY 1-800-387-1074, 6 a.m. to 7 p.m. PST, Monday through Friday, and 8 a.m. to 12 p.m. PST, Saturday.

Members call the number on the back of your membership card, or on the back cover of the Retiree Benefits Summary booklet.

BENEFITS AND COVERAGE	YOUR COSTS
Physician Services	
• Primary Care Physician	$10 copayment per office visit
• Specialist	$20 copayment per office visit
Emergency Department Services	
• Within the United States	$50 copayment, waived if admitted to the hospital within 24 hours for the same condition
• Outside of the United States	$50 copayment, waived if admitted to the hospital within 24 hours for the same condition.
Urgently Needed Care	
• In-area/in-network provider other than primary care physician	$10 copayment, waived if admitted to the hospital within 24 hours for the same condition
• In-area/non-network provider or out-of-area provider	$25 copayment, waived if admitted to the hospital within 24 hours for the same condition
Ambulance Services	$50 copayment
Inpatient Hospital Care	$250 copayment per admission for unlimited days*
Inpatient Mental Health Care	$250 copayment per admission, 190-day lifetime maximum
Skilled Nursing Facility Care	$0 copayment per day, days 1-20; $50 copayment per day, days 21-100 up to 100 days per benefit period,** three-day prior hospital stay is not required.
Home Health Agency Care	
• Home Care Visits	$0 copayment per visit

Retiree Benefits Summary Insert

Prepared Exclusively For: IBEW #413
Group Number 145666 (H0543 805)
Effective January 1, 2009 to December 31, 2009

BENEFITS AND COVERAGE	YOUR COSTS
Outpatient Mental Health Care	$20 copayment per visit
Partial Hospitalization Psychiatric Program	$50 copayment per day
Outpatient Substance Abuse Services	$20 copayment per visit
Outpatient Hospital Services (includes observation, medical and surgical care)	$125 copayment per surgery
Medicare-covered Outpatient Rehabilitation Services	
• Comprehensive Outpatient Rehabilitation (CORF)	$20 copayment per visit
• Cardiac and Pulmonary Rehabilitation	$20 copayment per visit
• Occupational Therapy, Physical Therapy and Speech and Language Pathology Services	$20 copayment per visit
Durable Medical Equipment (DME), Prosthetics, Orthotics (Corrective Appliances), Infusion Equipment and Supplies used in conjunction with the above	$0 copayment for each Medicare-covered item
Diabetes Self-Management Training	$0 copayment for Medicare-covered diabetes self-management training
Diabetes Monitoring Supplies	$0 copayment per item or up to a 30-day supply
Medical Nutrition Therapy	$0 copayment
Imaging Procedures, X-rays and Portable X-rays Used in the Home	
• Medicare-covered Standard X-rays	$0 copayment
• Complex Radiology Services and Imaging Procedures	$0 copayment
Laboratory Services	$0 copayment

SecureHorizons
by UnitedHealthcare

Retiree Benefits Summary Insert

Prepared Exclusively For: IBEW #413

Group Number 145666 (H0543 805)

Effective January 1, 2009 to December 31, 2009

BENEFITS AND COVERAGE	YOUR COSTS
Radiation Therapy	$0 copayment per visit
Medical Supplies	$0 copayment per item
Blood and Its Administration	$0 copayment
Kidney Dialysis	$20 copayment at a network facility or at a Medicare-certified facility within the United States
Bone Mass Measurements	$0 copayment
Colorectal Screening Exams	$0 copayment
Annual Screening Mammograms	$0 copayment
Pap Smears and Pelvic Exams	$0 copayment
Annual Prostate Cancer Screening Exams	$0 copayment
Cardiovascular Disease Testing	$0 copayment
Abdominal Aortic Aneurysm Screening	$0 copayment for a Medicare-covered screening
Medicare-covered Physical Exams	$0 copayment
Immunizations	
• Flu, Pneumococcal Pneumonia, and Hepatitis B Vaccines	$0 copayment
Medicare Part B-covered Drugs (Immunosuppressives, Oral Chemotherapy Drugs Including Anti-nausea Drugs, Inhalation Solutions)	$0 copayment
Outpatient Injectable Medications — Self-Administered	Your MA-PD Plan covers these medications under Medicare Part D. The copayments outlined in the **Outpatient Prescription Drugs** section also apply for these medications.
Outpatient Injectable Medications — Administered in a Physician's Office	$0 copayment
Outpatient Injectable Medications — Home Health	Your MA-PD Plan covers these medications under Medicare Part D. The copayments outlined in the **Outpatient Prescription Drugs** section also apply for these medications.

Retiree Benefits Summary Insert

Prepared Exclusively For: IBEW #413

Group Number 145666 (H0543 805)

Effective January 1, 2009 to December 31, 2009

BENEFITS AND COVERAGE	YOUR COSTS
Hemophilia Clotting Factors — (Self-Administered, Administered in a Physician's Office, Home Health)	$0 copayment
Antigens	$0 copayment
Chiropractic Services	
• Medicare-covered	$20 copayment per visit
• Routine (non-Medicare covered)	Not Covered
Dental Services	
• Medicare-covered	$20 copayment for each Medicare-covered dental service
• Preventive (non-Medicare covered)	Not Covered
Foot Care	
• Medicare-covered	$10 copayment per each Medicare-covered visit with your primary care physician $20 copayment per each Medicare-covered visit with a specialist or other health care professionals
Hearing Services	
• Medicare-covered diagnostic hearing exam	$10 copayment per each Medicare-covered visit with your primary care physician $20 copayment per each Medicare-covered visit with a specialist or other health care professionals
• Routine hearing tests for hearing aids (non-Medicare covered)	$0 copayment for routine hearing tests, up to 1 test every 12 months
• Hearing Aids	$500 hearing aid allowance every 36 months

SecureHorizons
by UnitedHealthcare

Retiree Benefits Summary Insert

Prepared Exclusively For: IBEW #413
Group Number 145666 (H0543 805)
Effective January 1, 2009 to December 31, 2009

BENEFITS AND COVERAGE	YOUR COSTS
Vision Services	
Eye care — medical need	
• Medicare-covered eye exam	$10 copayment for each Medicare-covered vision service with your primary physician $20 copayment for each Medicare-covered vision service with a specialist or other health care professional
• Medicare-covered eyewear	$75 allowance for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery
Routine Vision Services (non-Medicare covered)	
• Routine eye exam (refraction)	$20 copayment for each refractive eye exam with a network provider, limited to 1 exam every year
• Routine eyewear or contact lenses	Not Covered
Annual Routine Physical Examination (non-Medicare covered)	Medicare initial preventive physical exam covered in full, $0 copayment for annual routine physical examination
SilverSneakers® Fitness Program	You pay a $0 monthly membership fee for a Fitness Program through Contracted fitness centers. There is no visit or use fee when you use Contracted service providers. Call SecureHorizons to find a program near you. (All fitness programs may not be available in all areas. We may offer other fitness programs in your area.)
Optum® NurseLine℠	You pay $0 for calls to the NurseLine, available 24 hours a day, every day, to help you with health and medical questions, or to find quality providers or assist you in scheduling appointments. Simply call 1-877-365-7949, or for the hearing impaired, call the National Relay Center at 1-800-855-2880 and ask for the phone number above, 1-877-365-7949.

SecureHorizons
by UnitedHealthcare

Retiree Benefits Summary Insert

Prepared Exclusively For: IBEW #413

Group Number 145666 (H0543 805)

Effective January 1, 2009 to December 31, 2009

BENEFITS AND COVERAGE	YOUR COSTS
Wellness Advising	You pay $0 for this program designed to help you address certain particular conditions (for example weight management or fall risk issues) associated with defined medical conditions or criteria. The program provides you with access to advisors who assist you in making lifestyle behavior changes, as well as understanding risk factors associated with your health issues. The advisors provide you either printed materials or telephonic support to achieve your goal.
Treatment Decision Support	You pay $0 for calls to the NurseLine to help you make effective treatment decisions, find a quality doctor, schedule appointments, work more effectively with your doctor, find a resource for a second opinion or answer questions about a number of medical conditions and treatment options (back pain, knee or hip replacements, benign prostate problems, prostate cancer, breast cancer, benign uterine conditions (fibroids, endometriosis, uterine bleeding), coronary disease, obesity (bariatric surgery)). Simply call 1-866-247-8292, 9 a.m. to 7 p.m. (Central Time), Monday through Friday, or for the hearing impaired, call the National Relay Center at 1-800-855-2880 and ask for 1-866-247-8292.
Access Support	You pay $0 for calls to the NurseLine to help you find a quality doctor and schedule appointments. Simply call 1-877-365-7949, 9 a.m. to 7 p.m. (Central Time), Monday through Friday, or for the hearing impaired, call the National Relay Center at 1-800-855-2880 and ask for 1-877-365-7949.
Out-of-Pocket Maximum (annual)	None

* Inpatient Hospital Copayments are charged on a per admission or daily basis. **Original Medicare hospital benefit periods do not apply.** For Inpatient Hospital, you are covered for an unlimited number of days as long as the hospital stay is medically necessary and authorized by UnitedHealthcare or contracting providers. When you are admitted to an Inpatient Hospital and then subsequently transferred to another Inpatient Hospital, you pay the copayment charged for the first hospital admission. You do not pay a copayment for the second hospital admission; the copayment is waived.

** You are covered for up to 100 days per benefit period for inpatient services in a Skilled Nursing Facility, in accordance with Medicare guidelines. A Medicare benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row.

This is a highlight of benefits only and is not all inclusive of the Plan's benefits, services, limitations or exclusions. Please refer to the enclosed Retiree Benefits Summary and your Evidence of Coverage and Disclosure Information for additional details.

SecureHorizons®
by UnitedHealthcare

Retiree Benefits Summary Insert

Prepared Exclusively For: IBEW #413

Group Number 145666 (H0543 805)

Effective January 1, 2009 to December 31, 2009

BENEFITS AND COVERAGE	YOUR COSTS
Outpatient Prescription Drugs	**Your Medicare Advantage plan** includes a Medicare-approved Part D drug benefit. You automatically receive Medicare Part D prescription drug coverage as a part of your benefit plan. **$0–$4,350 Covered Drug Costs** **Retail:** You pay a **$10 copayment** Tier 1 preferred generic drug copayment/**$20 copayment** Tier 2 preferred brand name drug copayment/**$20 copayment** Tier 3 non-preferred drug copayment/**$20 copayment** for Tier 4 specialty drugs per Prescription Unit or up to a 30-day supply **Mail Service:** You pay a **$20 copayment** Tier 1 preferred generic drug copayment/**$40 copayment** Tier 2 preferred brand name drug copayment/**$40 copayment** Tier 3 non-preferred drug copayment/**$40 copayment** for Tier 4 specialty drugs up to a 90-day supply through our contracted Mail Service Pharmacy **After your yearly Out-of-Pocket Costs reach $4,350** You pay the greater of $2.40 for generic or a preferred brand name drug that is a multi-source drug, and $6 for all other drugs, or 5% coinsurance once your total out-of-pocket costs reach $4,350. **The MedicareComplete® Standard Retiree Formulary applies for both retail and mail service prescriptions. Bonus Drugs included.**

Retiree Benefits Summary Insert

Prepared Exclusively For: IBEW #413

Group Number 145666 (H0543 805)

Effective January 1, 2009 to December 31, 2009

Excluded Drugs

This section talks about drugs that are "excluded," meaning they aren't normally covered by a Medicare Prescription Drug Plan. If you get drugs that are excluded, you must pay for them yourself. We won't pay for the exclusions that are listed in this section (or elsewhere in this booklet), and neither will the Original Medicare Plan, unless they are found upon appeal to be drugs that we should have paid or covered.

- A Medicare Prescription Drug Plan can't cover a drug that would be covered under Medicare Part A or Part B.
- A Medicare Prescription Drug Plan can't cover a drug purchased outside the United States and its territories.
- A Medicare Prescription Drug Plan can cover off-label uses (meaning for uses other than those indicated on a drug's label as approved by the Food and Drug Administration) of a prescription drug only in cases where the use is supported by certain reference-book citations. Congress specifically listed the reference books that list whether the off-label use would be permitted. (These reference books are: American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and USPDI or its successor.) If the use is not supported by one of these reference books, known as compendia, then the drug is considered a non-Part D drug and cannot be covered by our Plan.

By law, certain types of drugs or categories of drugs are not normally covered by Medicare Prescription Drug Plans. These drugs are not considered Part D drugs and may be referred to as "exclusions" or "non-Part D drugs." These drugs include:

1. Non-prescription drugs (or over-the-counter drugs).
2. Drugs when used to promote fertility.
   (Your Plan Sponsor may have elected Bonus/Buy-Up prescription drugs as a supplemental benefit. Refer to your Prescription Drug Formulary Addendum.)
3. Drugs when used for the symptomatic relief of cough or colds.
4. Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale.
5. Drugs, such as Viagra, Cialis and Levitra, when used for the treatment of sexual or erectile dysfunction.
   (Your Plan Sponsor may have elected Bonus/Buy-Up prescription drugs as a supplemental benefit. Refer to your Prescription Drug Formulary Addendum.)
6. Drugs when used for treatment of anorexia, weight loss, or weight gain.
7. Drugs when used for cosmetic purposes or to promote hair growth.
8. Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
9. Barbiturates and Benzodiazepines.
   (Your Plan Sponsor may have elected Bonus/Buy-Up prescription drugs as a supplemental benefit. Refer to your Prescription Drug Formulary Addendum.)

Members or enrollees enrolled in a MA-PD Plan may not enroll in any other Medicare Part D prescription drug plan (including an individual or group Prescription Drug Plan (PDP)). If you are enrolling or are enrolled in any other Medicare Part D prescription drug plan (including an individual or group Prescription Drug Plan (PDP)), you will be disenrolled from this MA-PD benefit plan.

Retiree Benefits Summary Insert

Prepared Exclusively For: IBEW #413

Group Number 145666 (H0543 805)

Effective January 1, 2009 to December 31, 2009

SecureHorizons® Medicare Advantage plans are offered by United HealthCare Insurance Company and its affiliated companies, Medicare Advantage Organizations with a Medicare contract. This document is available in alternative formats. You must have both Medicare Parts A and B, and must reside in the service area of the plan. You must continue to pay your Medicare Part B premium if not otherwise paid for under Medicaid or by another third party. Your ability to enroll may be limited to certain times of the year. For more information contact your Plan Sponsor. HMO members must use network providers to receive plan benefits except under emergency or urgent care situations or for out-of-area renal dialysis. For PPO and HMO-POS members, with the exception of emergency or urgent care or out-of-area renal dialysis, it may cost more to get care from out-of-network providers. For PPO members, reimbursement is provided for all covered benefits regardless of whether they are received in-network. You may be able to get extra help to pay for your prescription drug premiums and costs. To see if you qualify for getting extra help, call: 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week; the Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778; or your State Medicaid Office. The plan's prescription drug benefit is only available to members of the Medicare Advantage with Prescription Drug (MA-PD) plan. If you are already enrolled in an MA-PD plan you must receive your Medicare Prescription Drug benefit through that plan. To receive the highest level of benefit you must use contracted network pharmacies to access your prescription drug benefit except in the case of emergency. The pharmacy network includes retail, mail order, long-term care, home infusion and I/T/U (Indian Health Service, Tribal or Urban Indian) pharmacy services. You may obtain your prescriptions from pharmacies outside the contracted network at a reduced benefit. Only Native Americans and Alaskan Natives have access to I/T/U Pharmacies through SecureHorizons® MedicareComplete®'s pharmacy network. Those other than Native Americans and Alaskan Natives may be able to access these pharmacies under limited circumstances (e.g., emergencies). If you have access to I/T/U facilities, you may have different out-of-pocket drug costs. For information about mail order, names and addresses of network pharmacies or for more information call Customer Service. The plan's contract with the Centers for Medicare & Medicaid Services is renewed annually. Availability of coverage beyond the end of the current contract year is not guaranteed.